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# Comments

## The Right to Refuse Medical Treatment: Under What Circumstances Does It Exist?

### I. INTRODUCTION

Today it is a common occurrence in a hospital for patients who require medical treatment to refuse such necessary care even if it results in their death.<sup>1</sup> Their reasons are usually grounded upon religious convictions, but also may be grounded upon their desire to avoid further medical procedure and the accompanying drudgery of life.<sup>2</sup> Physicians, as well as the entire hospital staff, are uncertain of how to deal with the legal and moral problems this situation presents. Legally, the doctors may be subjected to law suits for acting negligently, for not acting at all, or alternatively, for acting without proper authorization. Morally,<sup>3</sup> the physician, who is effectively prevented from treating the sick, is acting in conflict with his conscience and medical training as exemplified by the Hippocratic Oath.<sup>4</sup> Ostensibly, then, doctors may literally be "damned if they do and damned if they don't" when they fail to comply with the patient's desire to refuse medical treatment.

The legal issues involving refusal of medical treatment revolve around the precept that a doctor may only administer treatment when

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1. See Note, *The Dying Patient: A Qualified Right to Refuse Medical Treatment*, 7 J. FAM. L. 644 (1967), which noted the rise in the number of refusal cases in 1967. That this dilemma has become more prevalent since 1967 will be outlined in this comment.

2. For an example of a refusal based upon religious grounds, see *Aste v. Brooks*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965) (because of her religious conscience, the patient repeatedly informed the physician, who was treating her for a peptic ulcer, that she was not permitted to receive blood transfusions).

3. For a general discussion of the moral issue, see Wassmer, *Between Life and Death: Ethical and Moral Issues Involved in Recent Medical Advances*, 13 VILL. L. REV. 759 (1968).

4. The relevant part of the oath of Hippocrates reads as follows:

I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice which may cause his death. Nor will I give a woman a pessary to procure abortion. But I will preserve the purity of my life and my art. I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners (specialists in this art). In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction, and especially from the pleasures of love with women or with men, be they free or slaves.

J. STEDMAN, *STEDMAN'S MEDICAL DICTIONARY* 647 (23rd ed. 1976).

the patient has given his informed consent; otherwise, the physician may be subjected to legal action for malpractice in failing to obtain proper authorization.<sup>5</sup> An "informed consent" is an agreement between the doctor and patient whereby the patient grants his permission to allow the hospital staff to proceed with a specific method of treatment. State statutes and judicial rulings specify that before a patient signs an informed consent form he must be apprised of the nature of the proposed procedure, the associated risks, and of the possible alternatives to the treatment.<sup>6</sup> Therefore, where a patient refuses medical treatment and has not given his informed consent, a doctor cannot legally proceed.

Moreover, the option of refusing medical treatment exposes a more serious legal problem where the patient's choice may result in his death. Since there is an absence of strong judicial direction in the area, the law is unclear as to whether a patient may terminate his own life by refusing medical care. The United States Supreme Court has not specifically addressed the issue of a patient's right to refuse medical treatment and the lower state and federal courts that have considered the issue have not been consistent in their decisions. This judicial uncertainty is perhaps prompted by the recognition that another fundamental right, the right to die, may also be involved. If the doctor cannot legally proceed without the patient's informed consent, and the prognosis without treatment is death, then by permitting the patient to refuse treatment, there is an implicit recognition of the right to die—a right which has not yet achieved total and uncontroverted judicial acceptance. Yet, where the right has been recognized, it has been premised upon the all-encompassing right to privacy.<sup>7</sup> The

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5. A doctor may be sued in tort for a battery absent consent, for if he continues with a procedure, an unauthorized touching of the patient's body occurs. W. PROSSER, *LAW OF TORTS* § 18 (4th ed. 1971). The physician could also be held liable under a theory of negligent malpractice for violation of the duty to provide sufficient information to the patient so as to permit him to make a proper evaluation. Nonetheless, the patient must prove that he would not have submitted to the treatment if sufficient information had been provided and that the treatment or lack thereof proximately caused his injury. *Canterbury v. Spence* 464 F.2d 772, 790 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

6. See generally 40 PA. CONS. STAT. ANN. § 1301.103 (Purdon Supp. 1979); *Dunham v. Wright*, 423 F.2d 940 (3d Cir. 1970).

7. The right to privacy finds its roots in a series of Supreme Court decisions that established the right of privacy not as an enumerated right, but rather, as one within the penumbra of the fundamental rights. See, e.g., *Roe v. Wade*, 410 U.S. 113 (1973) (expanded right to privacy to encompass a woman's right to determine if she wants an abortion during the first trimester of pregnancy); *Griswold v. Connecticut*, 381 U.S. 479 (1965) (first decision to recognize the penumbra of rights theory). The expansive view of the right to privacy has been tempered somewhat by later decisions. See, e.g., *Doe v. Commonwealth's Attorney*, 403 F. Supp. 1199 (E.D. Va. 1975), *aff'd*, 425 U.S. 901 (1976).

privacy issue is important because the right to self-determination can arguably be extrapolated from it. The concept of self-determination is certainly not a new concept. As far back as 1914, Justice Cardozo expressed the opinion that every human being of adult years and sound mind has a right to determine what shall be done with his own body.<sup>8</sup> This right to privacy is, however, not absolute, and the extent of its limits remains open for interpretation; although the privacy right may arguably include the right to die, this issue also remains an open one. Thus, because the right to die question has not been resolved, the courts find difficulty in dealing with situations involving an individual's refusal of medical treatment.

This comment examines approaches which courts have taken in handling the legal ramifications of a recognition of a patient's right to refuse medical treatment. A review of the relevant compulsory medical treatment cases reveals that only under very special circumstances will the courts allow a patient to refuse treatment when that refusal will result in his ultimate demise. Moreover, these decisions indicate that courts have adhered to certain criteria when considering a patient's right to refuse treatment. In delineating the relevant criteria, courts have essentially focused upon the character of the patient involved, as well as upon the factual setting in which the right to refuse medical treatment is asserted. Specifically, the three patient categories include minors, competent adults, and incompetent adults. The two broad categories pertaining to factual settings involve emergency situations and nonemergency situations.<sup>9</sup> By categorizing cases in such

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(Virginia's statute limiting homosexual activity held not to be violative of the right to privacy).

8. *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 126, 105 N.E. 92, 93 (1914).

9. The framework for the analysis in this comment can be best explained by the following chart:

Patient	Factual Setting		
	Urgent Emergency	Nonurgent Emergency	Nonemergency
Minor	A	B	B
Competent Adult	A	C	C
Incompetent Adult	A	D	D

**KEY:**

- A - The patient can be treated without his consent. See notes 10-16 and accompanying text *infra*.
- B - Medical treatment will only be compelled if the nature of the illness is assessed to be less voluntary and more important to the overall health of the patient. See notes 17-29 and accompanying text *infra*.
- C - The trend is to respect the patient's refusal to medical treatment under these conditions provided that there are no dependent minors, the patient is not pregnant and is *compos mentis*. See notes 30-69 and accompanying text *infra*.

a manner, courts have provided the medical community with a limited practical set of guidelines within which they can safely operate. Unfortunately, in most instances courts have avoided deciding the underlying and more difficult issue of whether a right to die flows naturally and legally from the right to privacy. This comment will examine the duty of a physician to treat a minor or adult patient who refuses treatment under emergency circumstances, his obligation to generally treat minors despite parental refusal in nonemergency situations, his legal responsibility to abide by a competent adult's choice to refuse treatment in nonemergencies, and finally, his duty to secure proper consent to treat or not to treat incompetent adults under nonemergency circumstances.

## II. MINORS AND ADULTS: REFUSAL UNDER EMERGENCY SITUATIONS

Although it was noted earlier that it is important to make a distinction as to the type of patient involved—minor, competent adult, or incompetent adult—the distinction is unnecessary in the analysis of an emergency situation; all of the patients are treated in the same manner.<sup>10</sup> This proposition is implicitly supported by *Dunham v. Wright*,<sup>11</sup> a case in which the United States Court of Appeals for the Third Circuit ruled that the care of patients in an emergency was not restricted to one type of patient. *Dunham* established the general principle that in an emergency, where the doctor is unable to consult with the patient to secure the requisite informed consent, consent is unnecessary. Under the facts of *Dunham*, the physicians were forced to perform an emergency thyroidectomy without the patient's consent. The court determined that the need for the physician to obtain consent is obviated by an emergency which places the patient in immediate danger and makes it impractical to secure such consent.<sup>12</sup>

A corollary of the *Dunham* decision is that under a given set of circumstances, a doctor may treat a patient despite that patient's attempted refusal to consent. The rationale supporting this conclusion is that in order to have an adequate informed consent, the patient must understand the risks, alternatives, and consequences of the proposed treatment.<sup>13</sup> Implicitly, in an emergency, the patient would not be able

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D - The patient's choice to refuse medical treatment will be respected provided that the right is asserted by a guardian exercising a substituted judgment for that patient. See notes 70-91 and accompanying text *infra*.

10. See, e.g., 40 PA. CONS. STAT. ANN. § 1301.103 (Purdon Supp. 1979) (supports the proposition that all patients are treated in a like manner in an emergency situation).

11. 423 F.2d 940 (3d Cir. 1970).

12. *Id.* at 941.

13. *Id.* at 944.

to make adequate evaluations due to his serious medical condition. Therefore, if the patient were not capable of appraising his condition and understanding the risks, alternatives and consequences, he would not be able to render an informed consent. If the patient were incapable of giving his informed consent, it logically follows that he would be incapable of effectively refusing treatment for the same reasons.<sup>14</sup>

The delineation of the circumstances actually constituting an emergency is an important aspect of this special situation in which treatment can be performed without consent. The *Dunham* court stressed the concept of immediacy and rejected the plaintiff's definition that there should be a sudden or unexpected event which creates a temporarily dangerous condition usually necessitating quick action.<sup>15</sup> But *Dunham's* definition of an emergency situation is an elusive and open-ended one, which is determined by striking a balance between the right of the patient to choose the treatment he wishes to undergo and the freedom of the physician to practice responsible and progressive medicine without fear of frequent litigation.<sup>16</sup> According to *Dunham*, then, a court possesses a wide realm of discretion in deciding whether the facts of a particular case establish the existence of an emergency situation. Although *Dunham* insures that a physician will not be liable for acting without consent in an emergency, the decision, in failing to define concretely the parameters of an emergency situation, is not as practical in application as it first appears. Thus, physicians remain unsure of the proper course of action in an allegedly emergent situation where the patient is either unable to give his consent or has refused medical treatment. To resolve this dilemma, physicians, relying upon practical experience, have categorized emergencies into two distinct types: one is an immediate emergency in which minutes are crucial, and the other is nonurgent in nature, in which hours become critical. Unquestionably, a patient's refusal under the former situation would fall within the purview of the *Dunham* holding, but the latter situation may more appropriately be considered among the problems associated with refusal of treatment in a nonemergency setting.

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14. It is of interest to note that the *Dunham* decision, and the logical conclusions that may be drawn from that decision, focused upon the concern of urgency and finality associated with emergency situations when there was not time to debate the merits of the right to refuse treatment. The philosophical concern of personal choice or of the right to die arguably becomes secondary in these situations.

15. 423 F.2d at 947.

16. *Id.* at 942.

### III. MINORS: REFUSAL UNDER NONURGENT EMERGENCIES AND NONEMERGENCY SITUATIONS

When making the decision of whether or not to compel treatment in a nonurgent emergency and a nonemergent situation, the courts consider the specific status of the patient: where the patient is a minor, the courts require that an adult who is a parent or guardian must consent to treatment for the child, and the legislatures have enacted statutory provisions ensuring to the child the necessary treatment for the protection of his life and limb.<sup>17</sup> Moreover, the judiciary, invoking the doctrine of *parens patriae*, will disregard a parental decision if that decision does not appear to be in the best interest of the child. One of the earlier leading decisions dealing generally with parental interference was decided by the United States Supreme Court in 1944. In *Prince v. Massachusetts*,<sup>18</sup> the defendant state had a statute which provided that no minor shall sell on the streets or public place an article of merchandise. In addition, the law provided that it was unlawful for anyone to furnish a minor with any article which he or she knew the minor intended to sell in violation of the law. The plaintiff was convicted under this statute for directing her child to sell Jehovah's Witness material on the street. The Supreme Court upheld the conviction, concluding that neither the right of religion nor the right of parenthood may stand beyond regulation or limitation.<sup>19</sup> Parents, the court stated, may be free to become martyrs themselves, but this does not mean that they are free in identical circumstances to make martyrs of their children before the children have reached the age of full and legal discretion and can make legally enforceable choices on behalf of themselves.<sup>20</sup> *Prince* indicates the willingness of the United States Supreme Court to protect the child, despite objections of the parents. However, the question remains as to what extent the court will intercede in the parental-child relationship when the issue is a medical one.

Twenty years after the *Prince v. Massachusetts* decision, this question was addressed by the United States District Court for the

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17. Pennsylvania has enacted such a protective statute. See PA. STAT. ANN. tit. 35, § 10104 (Purdon 1977) ("Medical, dental and health services may be rendered to minors of any age without the consent of a parent or legal guardian when, in the physician's judgment, an attempt to secure consent would result in delay of treatment which would increase the risk to the minor's life or health").

18. 321 U.S. 158 (1944). Although *Prince* is not directly on point since the refusal of medical treatment was not in issue, it is of importance because it established certain parental duties in the case of minors.

19. *Id.* at 166.

20. *Id.* at 170.

Western District of Washington in *Jehovah's Witnesses v. Kings County Hospital*,<sup>21</sup> a decision which was premised upon the *Prince* case. The gist of the complaint in *Jehovah's Witnesses* was that the state court, in response to petitions of doctors and hospitals caring for the plaintiffs' children, had improperly compelled blood transfusions for those children. It was argued that the mere belief that the exercise of parental judgment contradicted sound medical advice did not justify taking the children from the protection of their parents. The court rejected the parents' argument and determined that a state, acting as *parens patriae*, may compel blood transfusions for a minor whose life is endangered. The court concluded that the parents' right to practice religion does not include the liberty to expose the child to death.<sup>22</sup> Clearly, the court demonstrated its willingness to protect the child from an untimely death. Because the court invoked such a strong paternal stance in *Jehovah's Witnesses*, the decision impliedly suggests that the minor himself does not have an enforceable right to refuse medical treatment when that refusal could result in his death. Yet, the decision, in failing to outline the permissible limits of judicial intervention, has not conclusively answered the prevailing question: namely, to what extent will a court interfere in the realm of "parental decision" when the physical welfare of a child is the issue before the court?

Faced with parental refusal based upon religious grounds, some courts have intervened when there was the possibility of some permanent affliction, even though the affliction may not have been life-endangering to the child. This was exemplified by *In re Karwath*,<sup>23</sup> a case in which three children were diagnosed as suffering sore throats and repetitious ear infections due to inflamed, infected adenoids and tonsils. The prognosis indicated that without an operative procedure, some permanent loss of hearing might have resulted, but that the lives of the children were not threatened; in light of these facts, the procedure was considered to be a voluntary one. The children's father believed in religious faith healing and refused to grant the required consent. The Supreme Court of Iowa, however, ordered that the children undergo the required surgery, concluding that the state has a duty to see that children receive proper medical care and treatment and that the parent has no right to deprive his children of necessary medical care. The Iowa court premised its decision upon the rationale that the state has the legal custodial duty of care, even in the absence

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21. 278 F. Supp. 488 (W.D. Wash. 1967), *aff'd*, 390 U.S. 598 (1968).

22. *Id.* at 493.

23. 199 N.W.2d 147 (Iowa 1972).



of immediate risk of life or limb.<sup>24</sup> Because of the potentially far-reaching effect of this case, in terms of the state's usurping the right of the parent to care for the child when the minor's life is not endangered, the decision has not been universally accepted.<sup>25</sup>

The Pennsylvania Supreme Court's decision of *In re Green*<sup>26</sup> has tempered the Iowa Supreme Court's expansive view. *Green* involved a mother who refused blood transfusions for her son because of her religious beliefs. The child, who suffered from a curvature of the spine, needed the blood for corrective surgery. Here, the court determined that the blood transfusion and surgical procedure, which did not involve a life-threatening condition, could only be compelled over the objection of the mother when the child himself expressed a desire to undergo such treatment.<sup>27</sup> Therefore, *Green* not only modified the thrust of the Iowa court's prior decision, which would have compelled medical treatment without concern for the seriousness of the patient's condition, but also suggested that a minor did have some control over his own physical well-being, at least in situations not involving a threat to life.

The trend is clear regarding compulsory medical treatment of minors: where the life of the minor is endangered, regardless of the religious objections of the parent, the minor will be treated; and where the minor is not involved in a life-threatening situation, the court may also compel treatment despite parental objection,<sup>28</sup> provided the minor

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24. *Id.* at 151. See also *In re Seiferth*, 309 N.Y. 80, 127 N.E.2d 820 (1955), which posed the question whether a fourteen year old child can be petitioned to come under the custody of the state so permission can be granted for surgery to correct the congenital defects of a harelip and cleft palate. The court held that the granting of such a petition was within the discretion of the trier of facts. But in dictum, the court stated that there was such a power on behalf of the state to take custody of the child, and to compel medical procedures where there was a serious physiological impairment which neither threatened the physical life or health of the child nor raised a risk of contagion to the public. *Id.* at 84-86, 126 N.E.2d at 822-23. See also *In re Sampson*, 29 N.Y.2d 900, 278 N.E.2d 918, 328 N.Y.S.2d 686 (1972), which reaffirmed the decision in the *Seiferth* case. The court held that religious objection to transfusion does not present a bar, at least where the transfusion is necessary to the success of required surgery.

25. See, e.g., *In re Green*, 448 Pa. 338, 292 A.2d 387 (1972). See also *In re Frank*, 41 Wash. 2d 294, 248 P.2d 553 (1952) (parent refused to have the child's speech impediment surgically corrected, and court determined that there was no reason to compel treatment because the child's life was not endangered); *In re Hudson*, 13 Wash. 2d 673, 126 P.2d 765 (1942) (court refused to compel medical treatment to correct a congenitally deformed arm of a twelve year old child because the mother, in her capacity as a parent, was to make the decision and, further, the child could survive with the defect).

26. 448 Pa. 338, 292 A.2d 387 (1972).

27. *Id.* at 348-49, 292 A.2d at 392.

28. See notes 21-27 and accompanying text *supra* for a review of the flexible approach the courts have taken in compelling medical treatment for minors over parental objection.

himself requests the treatment.<sup>29</sup>

#### IV. COMPETENT ADULTS: REFUSAL UNDER NONURGENT EMERGENCIES AND NONEMERGENCY SITUATIONS

Because there is usually time to secure an informed consent from a competent adult in nonurgent emergencies or nonemergent situations, courts need not assume a parental or protective role and, thus, have rarely compelled a competent adult to undergo medical treatment against his or her strenuous refusal. However, in very limited situations, which almost always involve a patient with a dependent minor, courts have reluctantly compelled treatment for the competent adult patient. The seminal decision is *In re President and Directors of Georgetown College, Inc.*<sup>30</sup> In that case, the Court of Appeals for the District of Columbia Circuit granted the hospital permission to administer blood transfusions to a patient in a nonurgent emergency, because the patient would have expired within several hours if she had not received blood to replace that which was lost due to a ruptured ulcer. The order was granted over the strenuous religious objections of the patient. The court's decision was premised upon three factors. Initially, the court reasoned that since the patient was *in extremis*,<sup>31</sup> hardly *compos mentis*,<sup>32</sup> and therefore barely able to understand the gravity of her condition, the state could assume the responsibility of guardianship, at least to the extent of authorizing medical treatment to save her life. Secondly, and most importantly, the court noted that the patient was a parent to a dependent minor. The court was seriously concerned that if the parent refused medical treatment and subse-

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29. See *Bothman v. Warren B.*, 92 Cal. App. 3d 769, 156 Cal. Rptr. 48, *hearing denied* (1979), *cert. denied*, 100 S. Ct. 1597 (1980), in which the California Court of Appeal held that when dealing with a mentally retarded child, whose well-being was in question, the court could appoint a guardian to override the parental choice and compel treatment only when it was in the best interest of the mentally retarded child. The court upheld the decision of the parents to forego lifesaving cardiac surgery after reviewing the particular facts of the case. The child was a twelve year old boy who suffered from Down's Syndrome. Because the affliction subjected the patient to a higher than average morbidity, the court determined that the parents' decision was in the best interest of the child. Although at first glance the decision appears to be inconsistent with the general rule that courts will compel treatment for children despite parental objection, the New York court's emphasizing the best interest of the child is in fact consistent with the underlying rationales of the general rule. For a sharply critical comment on the case see *NEWSWEEK*, April 14, 1980, at 112.

30. 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964).

31. "*Extremis*" is defined as being sick, beyond hope of recovery, and near death. *BLACK'S LAW DICTIONARY* 701 (rev. 4th ed. 1968).

32. "*Non compos mentis*" is defined as not being of sound mind, and embraces all varieties of mental derangement. *Id.* at 1200.

quently died, a voluntary abandonment of the child would result and the community would bear the burden of caring for the child. Because of this perceived state interest, the court of appeals was able to invoke the doctrine of *parens patriae* to prevent a voluntary abandonment of the child by compelling the parent to undergo the needed medical treatment.<sup>33</sup> Thirdly, the court considered self-homicide, the ultimate result of the patient's refusal to undergo medical treatment, to be a crime even though the basis of the patient's refusal was founded upon religious convictions.<sup>34</sup>

Interestingly enough, the *Georgetown College* court rejected the suggestion of the patient's counsel that the patient had the constitutionally protected authority to command her doctor to treat her under limitations which would produce death. Rather, the court determined that the principle which dictated that life and liberty are inalienable rights did not provide the answer to whether the state can condone martyrdom.<sup>35</sup> Since a further discussion of the constitutional issue is notably absent from the opinion, it would appear that the court attempted to avoid the real substantive issue of whether there is a constitutional basis for permitting a patient to choose death.

Subsequent courts have relied upon the *Georgetown College* decision to compel medical treatment for a competent adult; more specifically, these courts compel treatment where the patient appears unable to understand the gravity of the situation and where the patient's death would result in an abandonment of his children. However, when either or both of these *Georgetown College* considerations are absent, the courts have not been consistent in their findings. For example, not long in time after *Georgetown College*, in *United States v. George*,<sup>36</sup> the District Court for the District of Connecticut applied the *Georgetown College* reasoning to a slightly dissimilar factual pattern but nonetheless reached a similar conclusion. The *George* court ordered compulsory medical treatment for an adult patient who, like the patient in *Georgetown College*, was a parent to dependent minors, had been voluntarily admitted to the hospital, and refused blood transfusions on religious grounds; but who, unlike the *Georgetown College* patient, was probably *compos mentis*. This latter condition,

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33. 331 F.2d at 1008.

34. *Id.* at 1009.

35. *Id.* That the patient cannot dictate to her physician a course of treatment which approaches malpractice is further developed in *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965). See note 36 and accompanying text *infra*.

36. 239 F. Supp. 752 (D. Conn. 1965). The patient in *George* was suffering from a ruptured ulcer which caused serious bleeding within the gastrointestinal tract. Blood transfusions were required to replace sixty-five percent of the patient's red blood cells in order to prevent death.

however, was subject to question because the doctors were in disagreement concerning the patient's competency.<sup>37</sup> But the competency question was not deemed significant enough to preclude application of the *Georgetown College* principle,<sup>38</sup> especially when the court took into consideration the patient's minor children who would become wards of the state if their parent would be permitted to die. To buttress the argument for compelling treatment in the case, the *George* court developed an additional consideration: specifically, it was announced that where a patient voluntarily admitted himself to the hospital, he could not dictate to the attending physician a course of treatment that would amount to malpractice.<sup>39</sup> According to the *George* court, then, a doctor cannot be required to ignore the mandate of his own convictions and duty, even in the name of religious exercise, and the patient has no right to demand mistreatment.<sup>40</sup> By voluntarily admitting himself to a hospital for treatment, the patient has, in the court's view, also given his general consent for treatment. This viewpoint perhaps helps to explain that part of the *George* court's opinion which states that the patient could resist the court order compelling treatment by simply placing his hand over the injection area.<sup>41</sup> The patient, however, accepted the treatment without incident.<sup>42</sup> Providing this alternative to the patient could be construed as an indication that the court recognized the patient's right to revoke his prior decision to submit himself for treatment when he voluntarily entered the hospital. Regardless, it again should be noted that the court did not deal directly with the right of the patient to choose life or death; instead, the court focused upon the ancillary *Georgetown College* common law arguments.<sup>43</sup>

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37. *Id.* at 753. Although the patient may have appeared to be coherent, the record indicated that the treating physician doubted whether such a patient under medical circumstances of serious internal bleeding, where two-thirds of the blood volume had been lost, could be mentally competent.

38. *Id.* at 754.

39. *Id.*

40. *Id.*

41. *Id.* at 753. This has troubled commentators and caused them to speculate as to the reason for the court's action. See Riga, *Compulsory Medical Treatment of Adults*, 22 CATH. LAW. 105 (1976).

42. 239 F. Supp. at 754.

43. In *Georgetown College*, the court indicated that if treatment were compelled over the objection of the patient there would be no violation of the patient's religious practices. It was reasoned that where the court undertook the responsibility of giving informed consent for the transfusion, the patient did not violate his religious convictions since he never actually consented to any treatment; instead, the decision rested on the conscience of the court. 331 F.2d at 1009. The court indicated that this rationale resolved the dilemma for the patient who seeks medical treatment but simultaneously does not

*Raleigh Fitkins—Paul Morgan Memorial v. Anderson*<sup>44</sup> represented another situation in which medical treatment was compelled although the *Georgetown* considerations were not satisfied, for the adult patient was *compos mentis* and the existence of a dependent minor was questionable. In *Anderson*, a pregnant woman required blood, but had refused the necessary transfusion on religious grounds. The New Jersey Supreme Court determined that without the needed blood transfusions, both the unborn child and the mother would certainly expire. Because the welfare of the mother and the fetus were so intertwined, ordering treatment for the mother was done under the auspices of protecting the life of the unborn child.<sup>45</sup> Although the *Anderson* court recognized the ability of the adult patient to clearly understand the seriousness of her condition and to make her own decisions, the court's greatest concern was for the unborn child, who would be directly affected by the mother's decision. The status of the fetus *in utero* was considered to be equivalent to the status of a dependent minor, thereby providing the New Jersey judiciary with the opportunity to compel treatment.<sup>46</sup> By focusing upon the right of the unborn child to live, the New Jersey Supreme Court was able to avoid deciding the more difficult issue of the adult patient's right to die.<sup>47</sup>

However, two years later, in *John F. Kennedy Memorial Hospital v. Heston*,<sup>48</sup> the New Jersey Supreme Court did address the right to die issue. *Heston* involved an auto accident victim who was single, of majority age, and had no children. Although the victim seriously needed blood transfusions, she vigorously refused them. The traditional *Georgetown College* argument, which permitted a court to compel treatment for the adult by acting as *parens patriae* to protect any minor dependents involved, could not be utilized in *Heston*. The New Jersey court was convinced of the validity of the *Georgetown College* precedent, but the instant factual situation did not present the problem of dependent children. Unable to utilize *Georgetown College* to circumvent the right to die issue, the court confronted it.

At the outset, the opinion boldly stated that there was no constitu-

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want to act in contradiction of his religious beliefs. Utilizing this reasoning, the court was able to resolve the immediate medical problem without making a determination of the patient's right to die.

44. 42 N.J. 421, 201 A.2d 537, cert. denied, 377 U.S. 985 (1969).

45. *Id.* at 423, 201 A.2d at 537.

46. *Id.* at 424, 201 A.2d at 538.

47. Since the fetus was thirty-two weeks old, the problem of whether or not it was viable was not the issue. It is important to note, however, that the case was decided in 1964, long before nontherapeutic abortions were recognized and, therefore, before the whole question of when life begins was debated.

48. 58 N.J. 576, 279 A.2d 670 (1971).

tional right for anyone to choose death.<sup>49</sup> The opinion equated suicide with refusal to accept medical treatment<sup>50</sup> and reasoned that since suicide was a crime under common law, state intervention did not infringe on the constitutional right of any person attempting self-destruction.<sup>51</sup> Moreover, the court stated that although protection of religious beliefs is absolute, conduct in pursuance of these beliefs is not wholly immune from governmental restraint.<sup>52</sup> The court therefore rejected the patient's contention that her refusal to treatment was constitutionally protected as religious freedom because her faith ordained death. The New Jersey Supreme Court further decided that where the hospital and staff were involuntary hosts and their interests were contrary to the religious beliefs of the patient, it was not unreasonable to resolve the problem by permitting the hospital and staff to act in concert with their professional ethics.<sup>53</sup> Finding no constitutional right to die, the court compelled medical treatment over the patient's refusal. Although the issue was dealt with in a most conclusory manner and the opinion offered little supportive analysis, *Heston* was one of the first decisions examining the right to die question. After *Heston*, the intermediary New Jersey courts need not search for a circuitous means to compel treatment for a competent adult; instead, because it has been determined by the state's supreme court that no person possesses the right to die, the New Jersey courts can presumably intervene in all life-death situations to compel medical treatment for a competent adult.<sup>54</sup>

When a similar problem was presented before the Illinois Supreme Court, that court did not confront the constitutional right to die issue

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49. *Id.* at 580, 279 A.2d at 672.

50. *Id.* at 582, 279 A.2d at 673.

51. *Id.* at 580, 279 A.2d at 672.

52. *Id.*

53. *Id.* at 583, 279 A.2d at 673.

54. See also *In re Dell*, 1 Pa. D. & C.3d 655 (C.P. Allegheny 1975), in which a Pennsylvania Court of Common Pleas had reached a similar conclusion. The trial judge decided to compel the administration of the blood transfusion for a patient with a bleeding ulcer, despite the patient's religious objections. Adopting the *Heston* approach, the judge concurred with the rationale of *Georgetown College* but made it even easier to compel treatment. The judge argued that public policy abhors the act of self-destruction. Since this would be the inevitable result of ignoring medical treatment, it is not to be permitted. The judge determined that even though there were no dependent minors, medical treatment should be compelled because equal treatment of patients being denied the right to refuse medical treatment is a logical precept of equal protection under the law. *Id.* at 659. Finally, the trial judge concluded that compelling medical treatment did not constitute an infringement of freedom of religion for two reasons: namely, that there were no enforceable criminal sanctions for the practice of religion and that the practice of the dictates of one's religion was permissible except when a life or death situation is involved. *Id.* at 661.

with the same boldness exhibited by the *Heston* court, but rather looked to the *Georgetown College* precedent and general constitutional notions of religious freedom. Because the patient in *In re Brooks*<sup>55</sup> was an adult, fully conscious at the time of admission, without children, and fully aware that death would ensue without medical attention, the Illinois Supreme Court concluded that the *Georgetown College* considerations were not met, and thus, that medical treatment could not be compelled.<sup>56</sup> Even though the Illinois court concluded that it is foolish for a patient to refuse needed blood, it could not justify compulsion of treatment on that ground.<sup>57</sup> Alternatively, the court buttressed its conclusion of rejecting compulsory treatment upon the first amendment religious guarantees; in this regard, the court concluded that the government's imposition of limitations would be permissible only when the exercise of certain religious beliefs created a clear and present danger to the public health and welfare.<sup>58</sup> Accordingly, the court reversed the order of the lower court to appoint a conservator to order blood transfusions.<sup>59</sup> The significance of the *Heston* decision lies in the court's implicit recognition of the right to die, thus permitting an individual to choose a medical course of action that would result in his death.<sup>60</sup>

An intermediate New York appellate court reiterated this conclusion in *Erikson v. Dilgard*,<sup>61</sup> by holding that a competent adult patient who had no minor children was entitled to a limited right of refusing medical treatment. Since the patient ultimately decides whether or not the medical appraisal of his condition is correct,<sup>62</sup> and since he is the

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55. 32 Ill. 2d 361, 205 N.E.2d 435 (1965).

56. *Id.* at 368, 205 N.E.2d at 439.

57. *Id.* at 373, 205 N.E.2d at 442.

58. *Id.* at 374, 205 N.E.2d at 442.

59. *Id.* at 373-74, 205 N.E.2d at 443.

60. See also *Holmes v. Silver Cross Hosp.*, 340 F. Supp. 125 (N.D. Ill. 1972), in which the court said that a state should not have appointed a guardian to grant permission for a blood transfusion. The court reasoned that the conservator's order of treatment was in violation of the patient's religious beliefs and, therefore, abridged the first amendment freedom to exercise religious beliefs where a substantial state interest was absent. *Id.* at 130. Even though *Brooks* did not involve dependent minor children, the court relied on the case as a sound legal approach to the problem in terms of balancing the state interest against the individual's interest in protecting his first amendment guarantees. On its face, this factual distinction would appear to preclude the *Holmes* court from relying on the *Brooks* decision. The court, however, noted that the existence of a minor child only became known after the conservator had been appointed. The court stated that the defendants could not assert the presence of the child as an after-the-fact justification for the state-authorized actions since the state itself could not have balanced its interest with that of the decedent's first amendment right. *Id.*

61. 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962).

62. *Id.* at 28, 252 N.Y.S.2d at 706.

sole object of that decision,<sup>63</sup> the court resolved that the patient alone should be allowed to make the final choice of whether or not to proceed with the proposed treatment.<sup>64</sup> Because the focus of *Erikson* was not upon the *Georgetown College* considerations nor upon the general constitutional notions which *Brooks* had advanced, but rather upon the patient's right to self-determination, this decision came the closest to recognizing an individual's right to die as flowing from the right to privacy.

A Pennsylvania Court of Common Pleas went further and clearly enunciated the principle that there was a constitutional basis for recognizing that a patient's refusal of medical treatment could extend to the right to die. The court, in *In re Yetter*,<sup>65</sup> refused to appoint a guardian for a sixty-year old female for the purposes of authorizing a biopsy and surgical removal of her breast. It was concluded that the patient was fully capable of giving her proper informed consent,<sup>66</sup> and

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63. *Id.*

64. *Id.* See *In re Nemser*, 51 Misc. 2d 616, 273 N.Y.S.2d 624 (Sup. Ct. 1966), in which the court refused to order the amputation of the gangrenous leg of an elderly woman. The prognosis was not certain as to the benefits of such surgery, and the ability of the patient to make this decision was in doubt. *Id.* at 618, 273 N.Y.S.2d at 626. But the court, acting consistently with *Erikson*, upheld the patient's choice to refuse medical treatment. *Nemser* and the later case of *In re Melido*, 88 Misc. 2d 974, 390 N.Y.S.2d 523 (Sup. Ct. 1976), support the New York court's recognition of a right of choice which may result in demise. In *Melido*, the court held that the patient's right to be left alone could only be infringed where there was a compelling state interest. Though such an interest existed to compel treatment for a competent adult with children, no interest existed with respect to an unencumbered competent adult. *Id.* at 975, 390 N.Y.S.2d at 524. See also *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. Cir. Ct. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980), in which the Florida court held that a seventy-three year old man suffering from amyotrophic lateral sclerosis (Lou Gehrig's disease) should be permitted to be removed from life support devices. It was determined that the patient was capable of making this decision. His right to refuse treatment could only be tempered by a state interest, which was not present. Therefore, the court held that a competent adult who was suffering from a terminal illness, whose family agreed with his wish to discontinue life support treatment, and whose condition was not self induced, has the right to refuse medical treatment based on his constitutional right of privacy. *Id.* at 162.

65. 62 Pa. D. & C.2d 619 (C.P. Northampton 1973). This case is important even though it is of limited authority because it is one of the first to link the right to refuse medical treatment with the right of privacy. It should be noted, however, that many cases like *Yetter* are lower court decisions because the family or patient often will not seek an appeal. Generally, the treatment has been rendered, and the patients are not interested in pursuing any further legal redress.

66. See *Lane v. Candura*, 376 N.E.2d 1232 (Mass. 1978), in which the Appeals Court of Massachusetts held that a seventy-seven year old widow, who was suffering from gangrene in the right leg and foot, could refuse to consent to an amputation of the infected extremity. The rationale of the court was that the constitutional right to privacy included the right to self-determination. See also *In re Quakenbush*, 156 N.J. Super. 282, 383 A.2d 785 (1978), in which the court upheld a seventy-two year old patient's refusal to



that a guardian should not be appointed to override her choice. Despite its limited precedential value, the significance of the *Yetter* decision lies in the fact that the court premised its decision upon the theory that the right to privacy included the right of a patient in certain circumstances to refuse medical treatment even though that decision may seem unwise. A court has finally sought to examine and to express the medical issue in terms of the right of privacy.

Therefore, when dealing with competent adults in nonurgent emergencies or nonemergent situations, the courts are only partially in agreement. Under special circumstances, where the patient is responsible for minors and the patient's death would result in those minors becoming wards of the state, the courts will compel medical treatment.<sup>67</sup> But, there is a split in the decisions of the courts where the competent adult does not have any minor dependents and is *compos mentis*.<sup>68</sup> In those instances, the courts have fashioned first amendment constitutional arguments, have attempted to address the right to die issue, and have not been consistent in determining whether the patient may refuse treatment when the result will be his death.<sup>69</sup>

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have both of his gangrenous legs amputated. The court also recognized that the right to privacy included the right to refuse medical treatment despite an extremely dim prognosis. See generally *Suenram v. Society of Valley Hosp.*, 155 N.J. Super. 593, 383 A.2d 143 (1977), in which the New Jersey Superior Court held that an informed patient had a right to choose or to reject cancer treatment on the advice of her doctor. But see *Long Island Jewish Hillside Medical Center v. Levitt*, 73 Misc. 2d 395, 342 N.Y.S.2d 356 (Sup. Ct. 1973), in which the patient required an amputation of his lower extremity in order to save his life. The patient waived as to consent and then finally refused; this caused the court to question the patient's initial ability to consent. Therefore, the court appointed a guardian who made the choice for the patient and granted consent for the operation.

67. A recent case decided by the District of Columbia Court of Appeals was *In re Osborne*, 294 A.2d 372 (D.C. 1972). In holding that there was no compelling state interest justifying the overriding of the patient's religious decision not to receive blood, the *Osborne* court did not break any new ground. But the means by which the court came to this conclusion is of significance. The patient was a married male with two dependent minors. The court held that the mere fact that there were dependent third parties in and of itself did not constitute a state interest, as had been the indication in *Georgetown College, Brooks and Holmes*. The judge was able to ascertain that the children would be taken care of because of an arrangement made by the husband prior to his demise, and therefore, there was no state interest to compel treatment.

68. It is questionable whether any person who is rapidly approaching his demise is capable of being *compos mentis*. It would logically seem that a deteriorating medical condition would severely reduce the mental abilities of the patient to make such critical decisions.

69. It is interesting to note that all of the cases dealing with refusal of medical treatment by a competent adult involve treatment of patients who most certainly would die if they did not receive such medical attention. This can possibly be explained in that the hospital's liability is minimal when the patient refused treatment for a condition which would not result in his demise. Therefore, in such cases, the hospital is not reluctant to abide by the patient's wishes.

## V. INCOMPETENT ADULTS: PATIENT'S REFUSAL UNDER NONEMERGENCY SITUATIONS

Where the patient is considered competent, he is at least able to make a knowledgeable evaluation and decision with respect to his condition, thereby enabling a court to weigh the patient's desires along with the other important factors<sup>70</sup> in determining whether the necessary medical care should be compelled. But an incompetent, by the very nature of his mental status, is not able to aid the court in a determination of his medical care. The type of patient considered to be an incompetent would include, *inter alia*, patients legally adjudged to be incompetent, patients in a comatose state, and those patients apparently awake but incoherent, irrational or incapable of making a knowledgeable evaluation of their condition. The situation involving incompetents is becoming more prevalent due to the availability of newly advanced procedures and medical devices, including organ transplants, sophisticated respiratory and circulatory devices, and chemotherapeutic treatments, which contribute to the artificial prolongment of an individual's life, well after the individual has lost his cognitive abilities.

The first decision of major precedential value which addressed this difficult problem was rendered by the New Jersey Supreme Court in *In re Quinlan*.<sup>71</sup> The patient, a twenty-one year old woman, was diagnosed as comatose with severe brain damage, and required a respirator to sustain breathing. She was characterized as being in a chronic and persistent vegetative state.<sup>72</sup> The prognosis was poor because there was no form of treatment or cure available, and she could only be maintained in her present state with the aid of mechanical devices. As a result, the girl's father requested that the extraordinary medical treatment already being provided for his daughter be discontinued.

The New Jersey court determined that a decision to terminate medical treatment could be made by the father on behalf of the patient even though such discontinuance could result in her death.<sup>73</sup> The key

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70. For a discussion of the other factors involved in the courts' decisions, see notes 30-69 and accompanying text *supra*.

71. 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

72. *Id.* at 25-27, 355 A.2d at 655. The patient retained only the vegetative portion of the neurological functions, which included maintenance of temperature, blood pressure, and heart rate, while the actual breathing and heart function were mechanically assisted. The patient had also lost all cognitive functions, but there were no signs of brain death as defined in the Ad Hoc Committee of the Harvard Medical School Criteria. *Id.* at 24-27, 355 A.2d at 655-56. For a further discussion of the criteria see *A Definition of Irreversible Coma*, 205 J.A.M.A. 337 (1968).

73. 70 N.J. at 42, 355 A.2d at 664.

issue upon which the court focused was the constitutional right to privacy. A sliding scale analysis was employed. It provided that the state's interest in compelling treatment must be balanced against the individual's constitutionally protected right to privacy. The privacy right, the court determined, assumes prominence over the state interest as the bodily invasion becomes extensive and prospect of a good prognosis diminishes. Therefore, a point is ultimately reached in this balancing process whereby the patient's right to privacy supersedes the state's interest, and the patient's choice as to his treatment must be respected.<sup>74</sup> Under the circumstances in *Quinlan*, where the life sustaining treatment would have necessitated continuous and substantial interference with bodily privacy and where there was no medical expectation of recovery, the right to privacy was held to prevail over the state's interest.

Having determined that competent adults possessed a privacy right<sup>75</sup> which permitted them to choose medical treatment, the New Jersey Supreme Court then had to decide whether this right was applicable to incompetent adult patients. Toward that end, the court posed a hypothetical question: If Karen Quinlan could be lucid for a short interval (yet still be burdened with the same prognosis), and if she were aware of her irreversible condition, would she choose to terminate the treatment?<sup>76</sup> The court concluded that the answer would be in the affirmative.<sup>77</sup> It was reasoned that the patient's right to refuse treatment should not be destroyed by her personal lack of ability to exercise a choice. Therefore, the court decided that the patient's guardian should be legally permitted to assert the subjective choice of the incompetent.

The *Quinlan* decision clearly establishes the principle that the guardian for an incompetent adult patient has the legal right to refuse continuation of medical treatment for the patient, even if the ultimate result of the guardian's decision is the patient's demise. It should be noted that the guardian's decision cannot be arbitrary, but rather, must reasonably mirror the decision of the patient had he been capable of evaluating the circumstances.<sup>78</sup> It is interesting to note that the New

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74. *Id.*

75. *Id.* at 40, 355 A.2d at 663. For a discussion as to the existence of the right of privacy see note 7 *supra*.

76. *Id.*

77. *Id.* at 41, 355 A.2d at 664. Interestingly enough, Karen was removed from the respirator in May of 1976 and has since survived free of any mechanical devices. *NEWSWEEK*, March 3, 1980, at 14.

78. *Id.* at 41-42, 355 A.2d at 664. The opinion indicated that the guardian's judgment should be a type of substitute and not a best interest nature for incompetents. But, it is a best interest test at least in the sense that the personal interests of the patient are con-

Jersey Supreme Court eleven years earlier, in *Heston*, had asserted that there was no constitutional right to die.<sup>79</sup> The *Quinlan* court attempted to resolve this blatant contradiction by qualifying when the right can be advanced: apparently, the right cannot be asserted in instances where the patient's prognosis is good and a long fruitful life is assured, as were the circumstances in *Heston*;<sup>80</sup> alternatively, where the prognosis is poor and the patient will remain in a chronic vegetative condition, the state will not be permitted to override the patient's decision to choose death.

The subsequent decision of *Superintendent of Belchertown v. Saikewicz*<sup>81</sup> by the Massachusetts Supreme Court was concerned with the right of an incompetent to refuse treatment and essentially reiterated the basic thrust of *Quinlan*.<sup>82</sup> The facts involved a patient who was a sixty-seven year old, mentally retarded male with an intelligence quotient of ten and a mental age of thirty-two months.<sup>83</sup> Therefore, he clearly was unable to comprehend the seriousness of his condition, which was diagnosed as a form of leukemia.<sup>84</sup> The condition was not curable and the standard medical practice in such a case was to start the patient on a chemotherapeutic regimen, an extremely painful and expensive treatment which at best prolongs life for a short period of time.<sup>85</sup>

Considering the hopelessness of the patient's prognosis, the court-appointed guardian, in the forum of the Probate Court, decided to withhold consent to treatment. Six months later the patient died. The court, in affirming the guardian's decision, focused, as did the *Quinlan* opinion, upon the individual's right to self-determination as extrapolated from the right to privacy.<sup>86</sup> Since this right was available to a competent patient, the court stressed that the same right must also

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sidered, not the best interest of all society. See Brant, *The Right to Die in Peace: Substituted Consent and the Mentally Incompetent*, 11 SUFFOLK U.L. REV. 959 (1977).

79. See note 49 and accompanying text *supra*.

80. 70 N.J. at 39, 355 A.2d at 663.

81. 370 N.E.2d 417 (Mass. 1976).

82. See notes 71-80 and accompanying text *supra*.

83. 370 N.E.2d at 420.

84. The form of leukemia is mycoblastic monocytic leukemia, often called "cancer of the blood." The only known treatment is chemotherapy. 2 J. SCHMIDT, ATTORNEY'S DICTIONARY OF MEDICINE 388 (1979).

85. 370 N.E.2d at 421. Without medical treatment a patient suffering from mycoblastic monocytic leukemia would expire in a short time without much discomfort. *Id.* at 422.

86. *Id.* at 424. The Court specifically stated that: "The constitutional right to privacy, as we conceive it, is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life." *Id.* at 426.

be available for the incompetent.<sup>87</sup> Therefore, as in *Quinlan*, it was determined that the decision of the guardian has to be a substituted subjective judgment which would approximate as closely as possible that choice which the patient himself would have made.<sup>88</sup> But the *Saikewicz* court was troubled, because unlike the situation in *Quinlan*, Saikewicz would never have been able to make a knowledgeable evaluation or choice due to his severe mental retardation. This apparent dilemma was reconciled by determining that the substituted judgment should be made as if the patient were competent, while viewing the present and future incompetency of the individual as only one of the factors which would necessarily affect the decisionmaking process of a competent patient.<sup>89</sup> After weighing the factors in favor of treatment, and those favoring withholding treatment, the court found that the guardian's decision to refuse administration of chemotherapy was correct.<sup>90</sup>

The conclusion drawn from these two decisions is that an incompetent adult has the same right as a competent adult with respect to the right to refuse medical treatment and the right to privacy. The major difference is that the right of the incompetent must be asserted by a guardian who, in making his decision, must exercise a substituted consent which would reflect the patient's choice if he were capable of such a decision.<sup>91</sup>

## VI. CONCLUSION

This comment developed a model to encompass the most common

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87. *Id.* at 427.

88. It is argued that a competent adult would probably have opted for chemotherapy to prolong his life. But that factor is not a proper analysis. Rather, medical factors as well as personal needs must be taken into account. This becomes a personalized substitution approach by the guardian for that particular patient. Under these circumstances, refusal of treatment was appropriate. *Id.* at 430-31.

89. *Id.* at 431.

90. The factors considered to weigh in favor of administration of chemotherapy were: (1) the fact that most people elect chemotherapy and (2) the chance of a longer life. *Id.* The factors weighing against administration were: (1) patient's age, (2) probable side effects of treatment, (3) low chance for remission, (4) certainty that treatment will cause immediate suffering, and (5) patient's inability to cooperate with physicians. *Id.* at 432.

91. See *In re Eichner* (N.Y. App. Div., filed March 27, 1980), for a discussion of an incompetent patient's right to discontinue medical treatment. The New York appellate court, following the lead of the *Quinlan* and *Saikewicz* decisions, authorized the discontinuation of extraordinary medical treatment for a patient in a chronic vegetative coma. Specifically, the court determined that since there was a constitutional right to refuse medical treatment for competent adults, the same right must be available to the incompetent patient. The right, however, must be asserted by a guardian utilizing the substituted judgment standard.

circumstances under which a patient might assert a right to refuse medical treatment. According to the model, in a nonurgent emergency or a nonemergent situation only two categories of patients can request the discontinuation of medical treatment even though the ultimate result of such a choice may be death. These two categories include the competent adult patient who is free of any minor dependents, and the incompetent adult patient whose right must be asserted by a court-appointed guardian. Conversely, any patient—competent adult, incompetent adult, or minor—who faces an immediate emergent medical dilemma, where minutes are of the essence, could not refuse treatment if that refusal would result in his death. In such cases, there is not time for the physician to consult with the patient to obtain either a consent or denial of the treatment, and thus, the physician may promptly administer the required medical care. Where the patient is a minor, the model reveals that a parent or guardian must generally consent to treatment. However, should the decision of the parent or guardian not appear to be in the best interest of the child, the court will permit the state to interfere by invoking the doctrine of *parens patriae*. Moreover, the appearance of statutory controls designed to benefit the minor patient has been evidenced in a few states.<sup>92</sup>

Traditionally, permitting the patient to die when he could be treated was thought to be not only contrary to the physician's training and oath to heal, but also a form of suicide. However, these attitudes are waning. Recently, it has been determined that the doctor's interest is not absolute and that it is equally important to recognize the individual's choice to accept or to decline medical treatment.<sup>93</sup> In regard to the suicide argument, two points can be made: first, the patient who refuses treatment cannot be considered to have the requisite intent to die, for his choice is usually prompted by legitimate reasons, such as religious convictions; and second, if death does result from the refusal to accept treatment, the underlying cause of death is generally a natural one which the patient did not set into motion. In light of these

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92. It must be noted that these conclusions are drawn from a variety of state and federal court decisions and do not represent the final word since the United States Supreme Court has yet to address the issue.

93. For example, the court in *Saikewicz* addressed the existing antagonism between the ethical integrity of the medical profession and the individual's freedom of choice. The court wrote:

Prevailing medical ethical practice does not, without exception, demand that all efforts toward life prolongation be made in all circumstances. Rather, as indicated in *Quinlan*, the prevailing ethical practice seems to be to recognize that the dying are more often in need of comfort than treatment. . . . It is not necessary to deny a right of self-determination to a patient in order to recognize the interests of doctors, hospitals, and medical personnel in attendance of the patient.

370 N.E.2d at 426.

two factors, it is suggested that the patient cannot be viewed as taking his own life.<sup>94</sup>

Presently, a trend is beginning to emerge in the area of medical care which reflects a concern with the quality and dignity of human life, rather than with the notion of mere existence. In fact, this trend can be inferred from the decisions explicated within this comment. But because these decisions represent the views of various state and federal jurisdictions, they lack consistency in their approach. Consequently, the judiciary cannot be said to have supplied definitive answers to the refusal of treatment question. As a remedy to this situation, state legislatures, following the direction of California,<sup>95</sup> can introduce the concept of a "living will." Primarily, this type of legislation provides a legal basis for the hospital and physician to honor the choice of the patient even if it means discontinuing treatment necessary to avoid death. More specifically, a "living will" is a legal instrument analogous to the concept of a revocable conditioned trust. The patient's body is the res, the patient himself is both beneficiary and grantor, and the doctor and hospital are trustees. The doctor is given the authority to act in accordance with the direction of the trust instrument as to the type of medical care to be administered.<sup>96</sup> The document is deemed effective because it is created at a time when the patient is competent and capable of making a knowledgeable choice. That the legislature is assuming an active role in the area of refusal of medical treatment reflects the concern of the general public and their desire to have the issue resolved. But whether the problems accompanying the medical treatment issue are judicially or legislatively resolved is of little consequence. It is only important that the matter be finally decided so that as individuals, we can concern ourselves with "the great business of life [which] is to be, to do, to do without, and to depart."<sup>97</sup>

Henry Zee Shaub

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94. *Id.* at 431 n.11

95. The California National Death Act allows competent adults to draft specific instructions directing the discontinuation of life sustaining treatment when death is imminent in the judgment of the attending physician. CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1977).

96. Kutner, *Euthanasia: Due Process for Death with Dignity; The Living Will*, 54 INDIANA L.J. 201, 226-28 (1979).

97. Address by John Morley at Edinburgh (November, 1887) (quoted in NEW DICTIONARY OF QUOTATIONS ON HISTORICAL PRINCIPLES FROM ANCIENT AND MODERN SOURCES 693 (H.L. Mencken ed. 1977)).